Proposed STEMI Regulations Discussion Points
November 17, 2009

Proposed STEMI Regulation	Comments received	Change/Rationale	Discussion Issue
Section 1 - General Standards for STEMI Center Designation			
1. Page 2, (D) Cardiac Cath Lab	• No comments	• 75 PCIs per physician is recommendation only, cannot enforce recommendations. Did slight edits on language to make clearer.	• Should we keep recommendation?
2. Page 3, (F) Level II criteria	• Wanted alternative for those hospitals that were close but did not meet volume standard • Wanted more emphasis on outcomes as opposed to PCI volumes • 'Near but not at' needs clarification	• Modified this section to make language clearer for alternative criteria for those that do not meet the 36 primary and 200 elective PCI volume criteria. • Must meet at least one standard, either 36 primary OR 200 elective • If don't meet 36 primary PCI volume, then each operator should conduct at least 11 PPCI/year or receive oversight • If don't meet 200 elective PCI volume, then each operator should conduct at least 75 PCIs/year or receive oversight • Requires facility to have on-site surgical services • Requires facility to demonstrate that has PCI D2B process that is better than average performance measure standard since hospital conducts fewer procedures. • Requires facility to be comparable to state or national outcomes and benchmarks since conducts fewer procedures. • Need to define "near but not at"	• Any recommendations for this alternative language for Level II STEMI centers? • What is recommendation for minimum number of Elective PCIs if institution conducts 36 PPCIs, but <200 elective PCIs? • What is recommendation for minimum number of Primary PCIs if institution conducts >200 Elective PCIs but <36 PPCIs?
3. Page 4, (H) STEMI Medical Director	• Too many CMEs required, too costly.	• Clarified language so similar with general wording in stroke language. • Maintained number of CME requirements for the position • Eliminated the requirement for conference attendance for Level III and IV	• Should CME requirement be altered?
4. Page 4, (I) STEMI Program coordinator/manager	• Too many continuing education hours required, too costly	• Clarified language so similar to stroke • Maintained number of hours • Eliminated annual conference requirement for managers at Level II and IV.	• Are DHSS modifications acceptable?
5. Additional requirement for Level I	• Require provision for therapeutic hypothermia	• Recent evidence is indicating therapeutic value of this procedure.	• Should this be requirement for Level Is?
Section 2- Medical Staffing Standards			
6. Page 6, (B) 4. ED Physician	• Don't require specialty training in emergency medicine	• DHSS made change since there are a multitude of routes to become ED physician and hospital can assure credentials	

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7. Page 6, (B) 6. Hospitalists	• Don't specify physician type	• DHSS remove example	
Section 3 - Hospital Resources and Capabilities			
8. Page 7, (A) 1. ED staffing	• Too many continuing education hours required, too costly	• Decreased CMEs: Level I & II - 6 hours/year, Level III & IV- 6 hours every other year • Made same reductions for RNs • Separated requirement for 24 hour availability from CME requirement in order to clarify both	• Does group agree with DHSS changes
9. Page 8, (A)1.G ED Written Care Protocols		• Clarification done in wording	Any other clarifications needed?
10. Page 9, (A)2.J ED Equipment		• Clarified and changed parenteral fluids and blood to resuscitation fluids.	
11. Page 10, (C) Cardiac Cath Lab, 12. Page 11 (E) Operating room		• Clarified language	
13. Page 11, (G) Laboratory	• Change to align with trauma regulations	• Added blood bank or access provision for Level IV hospitals so aligns with current Level IV Trauma Proposed Regulations	
Section 5 - Research			
14. Page 12, (A)		• Reorder research examples to be in same order as given in stroke regulations	
Definitions			
15. Page 2, (X) Phase I cardiac rehabilitation	• Add definition	• Proposed definition added	• Agree with definition added?
General Comments			
16. Number of levels of STEMI centers	• AHA recommends that have only two levels - receiving and referring hospitals • Some recommend that delete the fourth level	• Group consensus is reflected in the four levels, which generally translates to two levels of receiving hospitals and two levels of referring hospitals and is reflective of the differing capacities of Missouri hospitals.	• Does group affirm current four levels?
17. General vs. Specific	• Some wanted more specific detail, some wanted less	• DHSS worked for appropriate balance and made modifications in 11/17/09 version where core standards were not compromised based on current evidence base	